



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

UHS OF TEXOMA INC

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-1514-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am filing this MDR to appeal for appropriate payment on this claim and to preserve our rights.

Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility \$1,362.75 for the MAR at 200%. Based on their payment of \$1,190.09, a supplemental payment of \$204.93 is due."

Amount in Dispute: \$172.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute 1/2/2014 ...

One year from disputed date 1/2/14 is 1/2/15. The TDI/DWC date stamp lists the received date as 1/22/15 on the requestor's DWC-60 packet, a date greater than one year from 1/2/14. The requestor has waived its right to DWC MDR.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 22, 2015	CPT Code 70450 and 70486	\$172.66	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W1 – Workers Compensation State Fee Schedule Adjustment

- CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC Rate
- 729 – This bill was reviewed in accordance with your first health contract. For questions please call 1-800-937-6824
- 767 – Reimbursed per O/P FG at 200%. Separate reimbursement for implantables (including certification) not requested per rule 134.403(G)
- CAC-P12 – Workers Compensation Jurisdictional fee schedule adjustment
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- CAC-193 – Original payment decision is being maintained upon review, it was determined that this claim was processed properly
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 724 – No additional payment after reconsideration of services. For information call 1-800-937-6824
- 728 – This bill was reviewed in accordance with your First Health Contract. For Questions please call 1-800-937-6824

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is January 22, 2015. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on January 22, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
		<u>3/26/15</u>

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.